U.S.C. 1302, 1320c–4, 1395ff(b), 1395hh, 1395ii, and 1395pp).

SOURCE: 37 FR 5814, Mar. 22, 1972, unless otherwise noted. Redesignated at 42 FR 52826, Sept. 30, 1977.

§ 405.701 Basis, purpose and definitions.

(a) This subpart implements section 1869 of the Social Security Act. Section 1869(a) provides that the Secretary will make determinations about the following matters, and section 1869(b) provides for a hearing for an individual who is dissatisfied with the Secretary's determination as to:

(1) Whether the individual is entitled to hospital insurance (part A) or supplementary medical insurance (part B) under title XVIII of the Act; or

(2) The amount payable under hospital insurance.

(b) This subpart establishes the procedures governing initial determinations, reconsidered determinations, hearings, and final agency review, and the reopening of determinations and decisions that are applicable to matters arising under paragraph (a) of this section.

(c) Subparts J and R of 20 CFR part 404 (dealing with determinations, the administrative review process and representation of parties) are also applicable to matters arising under paragraph (a) of this section, except to the extent that specific provisions are contained in this subpart.

(d) *Definitions.* As used in subpart G of this part, the term—

Appellant designates the beneficiary, provider or other person or entity that has filed an appeal concerning a particular determination of benefits under Medicare part A. Designation as an appellant does not in itself convey standing to appeal the determination in question.

Common issues of law and fact, with respect to the aggregation of claims by two or more appellants to meet the minimum amount in controversy needed for a hearing, occurs when the claims sought to be aggregated are denied or reduced for similar reasons and arise from a similar fact pattern material to the reason the claims are denied.

Delivery of similar or related services, with respect to the aggregation of claims by two or more provider appellants to meet the minimum amount in controversy needed for a hearing, means like or coordinated services or items provided to the same beneficiary by the appellants.

[55 FR 11020, Mar. 26, 1990, as amended at 59 FR 12181, Mar. 16, 1994]

§ 405.702 Notice of initial determination.

After a request for payment under part A of title XVIII of the Act is filed with the intermediary by or on behalf of the individual who received inpatient hospital services, extended care services, or home health services, and the intermediary has ascertained whether the items and services furnished are covered under part A of title XVIII, and where appropriate, ascertained and made payment of amounts due or has ascertained that no payments were due, the individual will be notified in writing of the initial determination in his case. In addition, if the items or services furnished such individual are not covered under part A of title XVIII by reason of §411.15(g) or §411.15(k) and payment may not be made for such items or services under §411.400 only because the requirements of §411.400(a)(2) are not met, the provider of services which furnished such items or services will be notified in writing of the initial determination in such individual's case. These notices shall be mailed to the individual and the provider of services at their last known addresses and shall state in detail the basis for the determination. Such written notices shall also inform the individual and the provider of services of their right to reconsideration of the determination if they are dissatisfied with the determination.

[55 FR 11020, Mar. 26, 1990]

§ 405.704 Actions which are initial determinations.

(a) *Applications and entitlement of individuals.* An initial determination with respect to an individual includes the following—

(1) A determination with respect to entitlement to hospital insurance or supplementary medical insurance;

(2) A disallowance of an individual's application for entitlement to hospital or supplementary medical insurance, if the individual fails to submit evidence requested by SSA to support the application. (SSA will specify in the initial determination the conditions of entitlement that the applicant failed to establish by not submitting the requested evidence);

(3) A denial of a request for withdrawal of an application for hospital or supplementary medical insurance;

(4) A denial of a request for cancellation of a ''request for withdrawal''; and

(5) A determination as to whether an individual, previously determined to be entitled to hospital or supplementary medical insurance, is no longer entitled to such benefits, including a determination based on nonpayment of premiums.

(b) *Requests for payment by or on behalf of individuals.* An initial determination with respect to an individual includes any determination made on the basis of a request for payment by or on behalf of the individual under part A of Medicare, including a determination with respect to:

(1) The coverage of items and services furnished;

(2) The amount of an applicable deductible;

(3) The application of the coinsurance feature;

(4) The number of days of inpatient hospital benefits utilized during a spell of illness or for purposes of the inpatient psychiatric hospital 190-day lifetime maximum;

(5) The number of days of the 60-day lifetime reserve utilized for inpatient hospital coverage;

(6) The number of days of posthospital extended care benefits utilized;

(7) The number of home health visits utilized;

(8) The physician certification requirement;

(9) The request for payment requirement;

(10) The beginning and ending of a spell of illness, including a determination made under the presumptions established under §409.60(c)(2) of this chapter, as specified in §409.60(c)(4) of this chapter.

(11) The medical necessity of services (See parts 466 and 473 of this chapter for provisions pertaining to initial and reconsidered determinations made by a PRO);

(12) When services are excluded from coverage as custodial care (§411.15(g)) or as not reasonable and necessary (§411.15(k)), whether the individual or the provider of services who furnished the services, or both, knew or could reasonably have been expected to know that the services were excluded from coverage (see §411.402);

(13) Any other issues having a present or potential effect on the amount of benefits to be paid under part A of Medicare, including a determination as to whether there has been an overpayment or underpayment of benefits paid under part A, and if so, the amount thereof; and

(14) Whether a waiver of adjustment or recovery under sections 1870 (b) and (c) of the Act is appropriate when an overpayment of hospital insurance benefits or supplementary medical insurance benefits (including a payment under section 1814(e) of the Act) has been made with respect to an individual.

(c) *Initial determination with respect to a provider of services.* An initial determination with respect to a provider of services shall be a determination made on the basis of a request for payment filed by the provider under part A of Medicare on behalf of an individual who was furnished items or services by the provider, but only if the determination involves the following:

(1) A finding by the intermediary that such items or services are not covered by reason of §411.15(g) or §411.15(k); and

(2) A finding by the intermediary that either such individual or such provider of services, or both, knew or could reasonably have been expected to know that such items or services were excluded from coverage under the program.

[55 FR 11020, Mar. 26, 1990]